NACD

National Advisory Committee on Drugs

The Role of Family Support Services in Drug Prevention

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A Report for the National Advisory Committee on Drugs

Authors:

Niall Watters and Duane Byrne

Unique Perspectives

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Niall Watters
Unique Perspectives

Foreword

I am happy to welcome this new report from the National Advisory Committee on Drugs (NACD) "The Role of Family Support Services in Drug Prevention." The importance of the family in Irish society is clear to all. Strong families play a crucial role in the development of children and provide them with skills for life. Accordingly, if we are to increase drug prevention we have to address the issue of supporting families, particularly those at risk. In order to examine this issue, the NACD undertook this research as part of their overall work programme approved by Government.

The research aimed to establish the extent to which current services explicitly identify drug problems as a target of their activities and whether family support work can play a positive role in the prevention of drug problems. The research also looked at the potential for expanding the scope of family support so as to enhance its capacity with regard to drug prevention. The results of this research help us to assess the current situation and identify what improvements can be made including making recommendations for more effective use of existing family support services as a means of preventing drug problems.

In this regard, as the report points out, there has been a welcome expansion of family support services in Ireland, but the majority of these are not aware of the positive role they could play in responding to and preventing drug problems. In this context, I believe that this is the appropriate time to broaden awareness and hopefully bring about improvements in services to families.

Research in this area contributes significantly to the implementation of the National Drugs Strategy, particularly in relation to improving prevention activities and recognising the important role of the family in this regard. As I have said on many occasions, I am always grateful for the research and analysis provided by the NACD and for all the on-going work of all of the members of the National Advisory Committee on Drugs.

Finally, I would like to congratulate the authors Mr Niall Watters and Mr Duane Byrne from Unique Perspectives on this comprehensive report.

Noel Ahern TD
Minister of State with responsibility for the National Drug Strategy

Preface

The NACD is tasked, as part of its terms of reference, with advising the Government about the prevention of problem drug taking in Ireland. In December 2001, the NACD published its first report "Drug Use Prevention, Overview of Research" by Dr Mark Morgan, which examined prevention programmes and methods in considerable depth. It is clear that prevention efforts both formal and informal take place in many different settings within the broader community, within schools and primarily within the home. Arising from the recommendations in the above report, the NACD through its Prevention Sub Committee commissioned further research. This Report is the result of a study of Family Support Services and their potential to contribute to drug prevention. The Report emphasises the preventive role of the family and as a result the key part that Family Support Services can, often without realising it, play in strengthening families and their individual members in their responses to the drugs phenomenon.

As is evidenced by other research the majority of those who seek treatment for heroin addiction are single and living with their families. The role of the family is, therefore, particularly significant. As the report makes clear, this can often result in further harm to the family. The ways in which the various family support services can help prevent these harms have been skillfully captured by the research team from Unique Perspectives, Mr Niall Watters and Mr Duane Byrne and the NACD is grateful to them for their expertise and professionalism. We are also indebted to Dr Mary Ellen McCann, Vice-Chairperson of the NACD and Chairperson of the Prevention subcommittee together with her colleagues Ms Mairéad Lyons, Ms Aileen O'Gorman and Dr Kieran McKeown (Independent Research Consultant) who acted as a Research Advisory Group to the project and who have given unstintingly of their time and knowledge.

The NACD were thus enabled to readily formulate recommendations to Government such as: increasing the capacity of services to respond through the provision of an appropriate level of resources/ funding together with appropriate training for staff in services. Interagency links and networks should be strengthened by building knowledge of local community issues and attitudes, improving communications and increasing awareness of services and activities. Develop relevant monitoring and evaluation tools to track the impact of service activities on families with regard to drug prevention.

The implementation of these recommendations, in the opinion of the NACD, will have a significant impact on those families most directly affected by problem drug taking in our society.

Dr Des Corrigan
Chairperson, NACD

Executive Summary

The family is generally considered one of the most important locations of socialisation, and therefore of influences, for its members and especially children. This emphasis on the family is evident in a raft of developments at policy level in Ireland over recent years. In tandem, there has been a welcome and ongoing increase in services that aim to support the family, more often referred to as family support services (FSS). The concept of 'family support' is generally understood as the provision of services and interventions that support families in carrying out their 'functions'. Such services often concern counselling, guidance and advice.

Aims of the Research

The role of the family - and family-based interventions - in responding to drug problems has been the subject of research internationally. The focus area of the present study is concerned in particular with family support services in their role of strengthening families to act as a buffer to drug problems. The purpose of this research is to assess FSS with a view to establishing the following:

1) the extent to which current services explicitly identify drug problems as a target of their activities;

2) the extent to which family support work (that is both work done by drug agencies and general family support work which does not explicitly identify drug issues as one of its targets) may be judged to play a positive role in the prevention of drug problems; and,

3) the potential for expanding the scope of family support so as to enhance its capacity with regard to drug prevention.

Research Methodology

The research process began with a literature review. This review was undertaken to inform the research about family support, FSS and their role in drug prevention. The survey phase of the research was preceded by a data mapping exercise based on the six categories of family support interventions identified by McKeown (2000): Therapeutic Work; Child Development and Education Interventions; Youth Work; Community Development; Parent Education Programmes; and, Home-based Parent and Family Support Programme. The survey used a self-completion questionnaire. 461 questionnaires were returned representing a response rate of approximately 26% of surveyed services. The study included two further stages, both of which were qualitative and involved in-depth interviews and/or focus groups with services, and separately, their clients.

Summary of Findings

The survey found that there are wide focus areas of what FSS do in responding to the problems that families present with. This view of what family support does is evident from the multiple ways FSS in the study describe their work across the six categories of interventions of family support, as well as in their funding and community and/or voluntary-statutory sector origins. These services however, differ in their response to drug problems depending largely on the extent to which they see drugs as a major, minor or not a focus of their work.

The study found that a minority, one fifth, of FSS state that drugs are a major focus of their work. The majority of surveyed FSS suggest, in contrast, that drugs are a minor, or not at all a, focus of their actions in supporting families. This differentiation of emphasis on drugs in the work of FSS is reflected in the proportion of their clients presenting with drug problems.

This study suggests that FSS with a major focus on drugs are those that provide services to families with drug problems and are best placed to do so. Nevertheless it implies that there is considerable potential for the majority of FSS to contribute to drug prevention in their family support work by increasing their capacity to respond to drug problems and adding this to their normal canon of services. A further implication of these findings is that this potential seems to be largely untapped presently.

The research suggests that drug use contributed to a range of family difficulties in the experiences of a large number of services that took part in the survey. Many of the problems with which families present to services, where drug misuse is a contributory factor, are also factors that increase the risk for subsequent drug misuse. Thus in families, drugs can be said to be both a cause and effect of family difficulties.

It is clear that family support services come in contact with clients and families that have drug problems. We know that family support can act to harness and strengthen family protective factors which prevent drug use. This suggests that the drug prevention role of family support has potential given increases in the capacity of FSS to work with drug problems.

FSS are unclear as to whether they have a legitimate role in responding to drug problems even where they state that drugs are a major focus of their work. It is clear from the research that training, skills and knowledge in respect of responding to drug problems is required for FSS. The need of support for services in responding to drug problems is significant across services.

The main areas identified that would help FSS play a greater role in responding to drug problems are the following: new programmes/initiatives, resources, promotion, co-ordination and integration, training, and mainstreaming of drug prevention in family support work

Key Issues Emerging from the Research

Although there has been a welcome expansion of family support services in Ireland, this study suggests that majority of these are not aware of the positive role they could play in responding to and preventing drug, including alcohol, problems. The prime example of this in the research is the very high proportion of services that may refer clients who present with drug-related problems. This should be tackled by means of introducing the role of drugs and drug prevention in the professional training of those who work in family support; increasing the awareness and knowledge of existing FSS in respect of family functioning and drugs prevention; and the introduction of ongoing training for those that work in and manage services.

FSS do not at present systematically measure their respective impact in terms of drug prevention. If they are to play a greater role in responding to drug problems, it is important that the variety of services can have some means to measure the effectiveness of their work in this regard. Due to the diversity of FSS and their respective roles, considerable thought and resources are required to assist services to develop evaluation and monitoring systems.

Many of the issues raised throughout the study involve communication. Communication needs to be addressed at a number of levels: inter-FSS communication; communication between FSS and local community and families; communication between regional/national central agencies/Government Departments and FSS providers; and communication between FSS and regional/National non-governmental bodies.

Glossary of Terms

(Problem) Drug Use: Problem drug use refers to the use of illegal and legal substances in a manner that result in physical or mental harm or less social well-being for the individual, for other individuals, or for society at large[1].

Protective Factors: A protective factor is an attribute or individual characteristic, situational condition and/or environmental context that inhibits, reduces or weakens the probability of probability of problem drug use (Clayton, 1992).

Risk Factors: A risk factor is an attribute and/or individual characteristic, situational condition and/or environmental context which increase the probability of problem drug use.

Primary Prevention: Primary prevention aims to prevent the onset of a drug related problem[2].

Secondary Prevention: Secondary prevention aims to intervene if a drug related problem is likely to occur (such as prevention in high risk groups) or if a problem exists but its symptoms are not yet fully manifest.

Tertiary Prevention (Type A): Tertiary prevention (type A) involves dealing with drug related problems once they are fully manifested. This is sometimes referred to as prevention of further harm in those addicted.

Tertiary Prevention (Type B): Tertiary prevention (type B) involved prevention of further problems recurring once they have been successfully treated. This is sometimes referred to as relapse prevention.

Role Legitimacy: Role legitimacy occurs for services where they and their staff feel that they have the authority to respond to the drug problems of their clients. It may be the case that the problems that services deal with are a result of drug use; however apprehension about the role legitimacy of services can often preclude a service from dealing with the root of problems where it is the misuse of drugs (Shaw et al., 1978).

Role Adequacy: Role adequacy refers to services not having, or perceiving that they do not have, the necessary skills and training with which to recognise and respond to drug problems that their clients present with.

Role Support: Role support for services occurs where they do not have available an appropriate and easily accessible source of support and knowledge in responding to drugs problems among their clients.

1 Adapted from Bryan et al. (2000)

2 Uhl (1998), cited in Morgan (2001).

Chapter 1
Background to the Research

The family is generally considered one of the most important locations of socialisation, and therefore of influences, for its members and especially children. Given the importance of the family in society, it has become an increasing focus of social policy developments in Ireland, as well as elsewhere, in recent decades. In the Irish context, this trend has been particularly evident since the mid-1990s, which represents something of a watershed in respect of a new-found focus on the family and thus on supporting the family (Daly & Clavero, 2002).

This emphasis on the family is evident in a raft of developments such as the establishment of the Commission on the Family (1995), and its subsequent report (1998), National Children's Strategy (2000), national guidelines on the protection and welfare of children, and major commitments in the National Development Plan to family related services (1999). Within the structures of the state this emphasis has been mirrored in the establishment of the Family Affairs Unit (1997) within a renamed Department of Social and Family Affairs. Part of this process also is the establishment of a Minister of State with responsibility for children in the Department of Health and Children.

In tandem with this focus on the family at policy level, there has been a welcome and ongoing increase in services that aim to support the family, more often referred to as family support services (FSS). The clearest illustration of this is seen with the establishment of the National Family Support Agency in 2002 under the aegis of the Department of Social and Family Affairs[3]. The concept of 'family support' is generally understood as the provision of services and interventions that support families in carrying out their 'functions'. Such services often concern counselling, guidance and advice (Daly & Clavero, 2002). It should be noted however that defining family support is not a straightforward task and as such family support is perhaps best understood as a broad term covering a diverse range of elements, activities and methods that support families (McKeown, 2000).

The role of the family – and family-based interventions – in responding to drug problems has been the subject of research internationally[4]. This research suggests that the family can play an important role in both protecting its members from, and contributing to the risk of, drug problems.

The Role of the Environment, Risk and Protective Factors in Drug Problems

The UK Advisory Council on the Misuse of Drugs (ACMD) in an important report explored the role of the human environment in the development of drug problems (ACMD, 1998). In this publication, the ACMD viewed the human environment as a complex interactive arena in which individuals live, and where they are both influenced by and influence this arena. The ACMD divides the environment-based influences in the development of drug problems into two components, namely: micro-environmental influences – those in the more immediate aspects of an individual's interpersonal environment – and the macro-environmental influences – comprising broad social, economic and cultural factors.

3 Other relevant development in services that support families include the statutory obligation placed on health boards to provide family support services through the Child Care Act 1991, the child protection guidelines, the establishment of the Springboard family support projects on a pilot and now mainstream basis, and following the recommendation of the Commission on the Family, family related community-based mediation and counselling together with a national network of community based family support centres.

4 Mitchell et al. (2001); Mendes et al. (2001); Bancroft et al. (2003); Kumpfer & Alvorado (1995); Merikangas et al. (1998).

Micro-environmental factors, which can often be interrelated, include a number of key features in the individual's environment such as access to drugs and drug culture, personality traits, circumstances which accommodate continuing drug use, lifestyle etc[5]. Given the existence of some of these features, ACMD state that there is widespread agreement that the two key influences in the micro-environment of individuals are the family and peer groups and their interrelationship. In terms of friendship and peer groups, evidence suggests that these networks are normally the means by which individuals first get introduced to drugs. Rejecting the concept of peer 'pressure', ACMD suggest that peer processes involve friendship networks and youth culture, rather than pressure which posits the individual as a passive victim. They suggest that the peer process includes shared attitudes, beliefs and socialisation. In terms of the influences on family functioning (and therefore the work area of FSS) this account affirms that it is difficult "to extract micro-environmental influences of the family and peers from the wider environmental contexts of the neighbourhood, poverty and social exclusion" (ACMD, 1998).

Turning to ACMD's discussion of macro-environment, these can be viewed as playing a role in influencing the development of drug use in conjunction with micro level factors. Macro-level influences cover broad social, economic and cultural factors. The wider socio-economic context is considered by ACMD to clearly contribute to drug related problems. While less clear in its relationship to individual drug use patterns, this influence is most apparent where there is a high correlation between drug-related problems and disadvantaged urban areas. Thus ACMD intimate that deprivation, and its multiple elements (income poverty, poor housing, educational disadvantage, limited employment/ income opportunities etc.) are "likely to make a significant causal contribution to the cause, complications and intractability of damaging kinds of drug misuse" (ACMD, 1998). One important implication of this in the present context is that efforts to target drug problems are ineffective unless they target related issues such as social exclusion, employment, education and training, housing etc. The ACMD observe that "such a complex and overlapping set of goals and objectives would seem to insist on some form or other of 'multi-agency' strategy" (ACMD, 1998).

This account clearly demonstrates the complicated array of factors that can contribute to drug related problems. We can of course add to these human environmental factors other factors such as those relating to biology and genetics. In respect of causality, ACMD note, in line with other commentaries (Lloyd, 1998), that it is not a one-way street. In this regard, they point out that family dysfunction can contribute to drug problems, as well as drug use resulting in family problems. This two-way cause and effect is also applicable to unemployment and drugs, peer networks and drugs, community problems and drugs etc. They conclude that this underscores the importance of involving all actors in communities beyond those individuals with drug problems and their families.

Lloyd (1998) concentrates on the environmental causal factors for the development of drug misuse in terms of risk factors. He suggests the risk factors are important not only because of the manner by which they add to the understanding of causality in the development of drug problems, but because they also are fundamental to the development of preventive approaches. Lloyd's overview of literature on risk factors suggests that (risk) factors associated with the development of drug problems relate to the following:

5 Access to drugs in an important part of this and will involve material access to drugs but also cultural or symbolic access relating to whether drugs taking and specific drugs are fashionable. A second element in the micro environment concerns personality factors which might include a predisposition toward taking risk or toward sharing in the experiences of others such as peers and friends. Thirdly, the motivation for continuing use can also be present, these will act to facilitate an individual to experience drug use as pleasurable and includes contact with peers who are socialised into drug use, drug taking as affordable monetarily and socially. This introduces the concept of lifestyle whereby some drugs maybe acceptable and others not. It is important to not that environmental factors and the micro or interpersonal level can also play a role in encouraging those with drug problems to give up.

- Family: this is dealt with in the following section;
- Schooling: there is a correlation in general between low educational attainment and drug problems;
- Peers: this is in keeping with the discussion above but this account also underlines the important influence of siblings and partners;
- Conduct disorder, crime and delinquency: problem drug users in general experience previous conduct disorders. This overlaps with schooling in that expulsion from formal education is highly predictive of later drug problems;
- Mental disorder: there is a relationship between psychiatric disorders and later drug-related problems;
- Deprivation: this is described above however this account also underlines the dynamic and changing nature of deprivation and its relationship with drug problems;
- Early onset of drug use: this was also shown to be a predictor of later drug problems.

Importantly, Lloyd highlights that the literature here conveys that many of the individual risk factors are interconnected. In this sense, risk factors for drug problems may also simultaneously be predictors of other problems. The best example here is where risk factors for drug-related problems in young people also predict other problem behaviours. Above all risk factors highlight who is at risk of developing problems related to drugs. The implication of risk factors and their interrelationship is the need for multi-dimensional approaches at the level of prevention. Of particular importance in regard to services that do not necessarily focus on drugs as part of their work, he states that "drug-focused work will need to be embedded within other work with their groups and this will require interagency approaches" (Lloyd, 1998).

Drug Prevention and Family Risk and Protective Factors

The family is therefore just one of many related sites involved in the development of drug problems. It is the focus area of the present study in which **we are concerned in particular with family support services in their role of strengthening families to act as a buffer to drug problems.**

The impetuses of addressing the role of the family in prevention dates back to research that acknowledges the psychological role of the family in drug problems. It has been shown that the family is a critical part of the socialisation process for children and young people and that it has the potential to guide young people especially away from problem behaviours and drug use (Kumpfer et al., 1998). While family management, parenting skills, and levels of caring in families have all been strongly linked to substance misuse and related activities among young people, Kumpfer et al have also discussed the reasons why the family is a risk factor for drug problems at societal level across countries. They believe that the reasons for this are the increasing numbers of children being raised in deprivation and poverty, which leads to parents working more hours and being in a position to devote less time to the family as a result. The need for support for families, dealing with social/economic issues, in addition to the myriad of family issues in their life cycle, seems crucial. They also note that drug culture can become infused within deprived areas as a foundation, in the absence of other opportunities, of local economic opportunities and income generation

for families and young people (Kumpfer et al., 1998). The research also shows that family members, siblings, children and even relatives of persons with drug problems are more likely on average to have higher rates of substance misuse than populations at large (Merikangas et al., 1998). This demonstrates the interconnectedness of the family with the other environmental causes or risk factors for the development of drug problems.

The research suggests that within the family there are specific and non-specific risk factors in how families enhance the risk of drug problems. Specific risk factors include (1) exposure of children to drugs, (2) providing negative role models such as using drugs as a coping mechanism, and (3) parental attitudes to drugs and drug availability. Non-specific risk factors toward drug problems include:

- dysfunctional families and conflict;
- parental relationship conflict;
- poor parenting;
- exposure of children to stress;
- family psychological illness;
- neglect and abuse (Kumpfer et al., 1998).

In recognition of the role of some family circumstances in the development of drug problems, family-based drug prevention places an emphasis on the family strengths and therefore also the family protective factors used to address the problem of drugs.

Evaluations of international family-focused prevention programmes have revealed that such programmes have the capacity to increase family protective factors and reduce family risk factors in respect of drug problems[6]. Families, with a range of problems that are high risk, have also been shown to benefit from family strengthening strategies and programmes. The research suggests that their effectiveness however is also dependent on ensuring that such programmes are carefully tailored to the age, gender and social circumstances of families and their members (Kumpfer, 1998). The programmes work by diminishing family risk factors for drug problems through strengthening families. Families are strengthened therefore through focusing on enhancing the factors that have been shown to protect family members from problems related to drugs.

The family protective factors that family-based drug prevention interventions look to develop and strengthen include the following:

- enhancing the caring role of the family and its members;
- emotional support;
- realistic development of expectations on the part of parents to their children;
- the existence of opportunities for meaningful family involvement;
- supporting dreams and goals; setting rules and norms; and,
- maintaining strong family support networks (Kumpfer, 1998).

6 Mitchell et al. (2001); Kumpfer (1996); Catalano et al. (1998); Schweinhart (1993), cited in Mitchell et al. (2001).

In addition to building protective factors in families, the research suggests also some of the connected ways in which family support can make a positive contribution to drug prevention. Firstly, family support that has a positive contribution to drug prevention is carefully tailored to the needs and experiences of their clients in terms of drugs and family functioning[7]. This is similar to McKeown's conclusions in respect of 'what works' broadly in family support with vulnerable families (McKeown, 2000). In terms of family support's capacity to respond to drug problems, research suggests that the capacity of services to respond to drug problems also has to be addressed. The main elements of this capacity are: resources and appropriate funding models; training for staff; development of interagency links and protocols; and knowledge of community attitudes (Mitchell et al., 2001).

The implication of the research into the role of the family in drug prevention suggests that services which strive to strengthen and improve the functioning of families can have a positive influence in strengthening the protective factors within families and therefore act to prevent drug problems. In other words, providing support to families can contribute to the families' positive role in responding to drug problems.

Families and Drug Problems

Problem drug use has considerable negative impacts for families and their functioning. The effects of drug misuse on the family overall include deteriorating relationships and making the family dysfunctional, psychological and social problems, increased stress, depression and behavioural disorders, financial difficulties, all of which can contribute to family breakdown and negative impacts on adult and child members of the family[8]. The effects can be short and longer term leading to physical and psychological health problems.

In the Irish context, a number of studies have assessed the impact of drug problems on families and, in particular, the impact of illicit drugs on families in deprived areas[9]. In the case of Heroin, these compelling works explore the impact of drugs on families and family members in inner city areas of Dublin. In this respect, the communities themselves are marginalised further by drug problems, have a sense of powerlessness and heroin related problems in such communities are seen to sustain the cycle of poverty and social exclusion. These accounts underline that drug problems are "both 'symptom' and 'symbol' of the entrenched and complex dynamics of marginalisation and alienation" (Murphy-Lawless, 2002).

For the families in these depictions, drug problems lead to complications in their internal functioning, isolation, family break up due to imprisonment or fatalities, costs and debt in caring for a family drug user, a reduction in the resources of the family to care for all its members where such resources are directed toward a drug using member, and overall, drug-related problems can lead to health difficulties for all members of affected families.

Drug problems in these communities are also shown to have different impacts on family members depending on their position and role in the family and extended family as the case may be. For parents, these accounts note the sense of guilt, personal failure, helplessness and isolation where they or a child are drug users. These descriptions demonstrate also how drugs can affect younger children

7 Kumpfer & Alvarado (1995), Collins & Shanahan (1998).

8 UNODC (2002), Bancroft et al. (2003).

9 See for instance Murphy-Lawless (2002), McCarthy et al. (1997).

by decreasing the availability of safe play space, requiring additional supervision when playing, and significantly, a loss of innocence through the need to alert young children to the existence and dangers of drugs within their immediate communities. What this depiction also conveys is that children are likely to be at high risk, due to the prevalence within families, peers and communities in which they socialise, of becoming drug users in later life. In terms of the extended family, there is also a trend whereby the grandparents are required to shoulder the considerable burden of caring for grandchildren, without state support in most cases, where the parents of the children concerned are drug users. There is also a striking similarity between the impact Heroin has on families that these accounts suggest and a relatively recent survey of community-based drug projects in respect of the impact of cocaine on families[10].

These portrayals show also how families feel that they are neglected by services due to the presence of a drug using member, that they are not provided with the supports they require to cope with drug problems and, overall, convey a picture of service provision in which there is little clear strategising in terms of drugs and drug prevention.

In part, this is the reason why family support groups have been set up in these areas. Similarly, 'families have a hard earned experience and knowledge around drug issues and its effects" (Citywide Family Support Network, 2003). The needs of families in respect of the development of such groups, as noted in the reports, are peer support, counselling, information, education and training. They suggest that effects of drug use necessitate also the provision of childcare and family support. As such, family support is seen as a primary, secondary, and tertiary (type A and B) prevention strategy[11] in such communities. McCarthy et al. (1997) report that "most of the agencies… felt there was a need for more family support services, and the family themselves also identified family support services as a need."

What is clear from these sources is that drug problems are multidimensional in both their causes and manifestation in respect of families; this by implication requires that supports, intervention and responses must be also multifaceted and therefore range across a broad number of services that provide supports to families. In this sense, Murphy-Lawless (2002) suggest that the support needs revolve around strengthening individual capacities, strengthening community capacities, ensuring group and child centred activities and responding to parents in need, all of which are the work of family support as we shall see below.

What these accounts also demonstrate is that the provision of (family) support to these families has the potential to prevent problem drug use across the scope of prevention from primary to tertiary levels. In this regard, family support is needed in this scenario as a prevention strategy for children and also a form of prevention for those using drugs and their families (Murphy-Lawless, 2002).

10 These effects include increases in tension and aggression within the family, not knowing what to do, debt problems, family break up, and limiting parenting skills. Citywide Drugs Crisis Campaign (2004).

11 See glossary for definition of primary, secondary, tertiary prevention.

Family Support Services

The family is one of the core socialisation agents for most individuals; however, like all the major institutions in societies it is in a state of flux and undergoing change (Daly & Clavero, 2002). As we noted earlier, supporting families in this context has received significant interest in the last few years (McKeown, 2000). Despite this emphasis, there are few definitions of what family support is. In a range of official documents in which there is reference to supporting families, there is no corresponding definition. In Ireland until recently, family support has been concerned with the support and protection of children. However since the Report of the Commission on the Family, family support services have turned to focus also on parenting[12].

At the outset, Canavan et al. (2000) observe that family support cannot be conceived as "a neatly bounded set of concepts and activities", they suggest in contrast that it is "more akin to a repertoire of explanatory and prescriptive ideas drawn from various contexts or interventions and associated academic fields of enquiry." In the context of this diversity, McKeown observes that family support is best understood as an umbrella term covering a wide range of services which vary along a range of points such as their target group, the professional background of a service provider, orientation of service, problem addressed, activities and service setting. This broad scope of what family support is suggests that there is variation in views and experiences as to the nature of working with families, it may be the case that this diversity may simply reflect the diversity of experiences and support needs that families have (McDonald et al., 2002). Murphy (1996) notes that FSS are comprised of local and national voluntary bodies as well as those of the state and involve professionals as well as volunteers, social and community workers, childcare and youth workers, pre-school teachers, public health nurses, adult education providers, etc.

The complexity of family support as a method of prevention in childcare and in this case in responding to drug problems is also broached by Murphy (1996) who maintains the importance of two issues: firstly, that families are not unitary wholes but are made up of members between which there may be conflicts of interest and secondly, that families cannot be understood in isolation from the economic, political and social system of which they are a part. In this sense, this account suggests that family functioning, and therefore some of the major focus areas of FSS, are impacted negatively by disadvantages in income, health, education, the environment and the personal domain (Murphy, 1996). This suggests that family support, if it is indeed to provide the full range of supports that families need, should necessarily cover a wide spectrum of influences on families and their functioning. What is clear however, is that family support should be viewed as complex area that covers a wide array of service types and interventions. This is evidenced also by the scope of the six broad categories into which services that are considered 'family support' fit: therapeutic interventions, parent education, child development and education, home-based parent and family support programmes, youth work and community development[13].

12 Daly & Clavero (2002), Commission on the Family (1998).

13 This is adapted from McKeown (2001). A larger discussion of these categories of family support is presented in Chapter 3.

The Commission on the Family noted that one of the desirable ends of family support is the building of strengths in families; indeed this was explicit in the title of the Commission's final report "Strengthening Families for Life". This view is captured by Gilligan's notion of family support, which suggests that it seeks to:

- enhance the morale, supports and coping skills of all children and parents;
- maximise the resilience of families and children to stress;
- integrate children and families into supportive institutions such as the family, the extended family, schools and communities (Gilligan, 1995).

Gilligan suggests that family support can be conceived as operating in three categories of services: developmental, compensatory and protective. Family support can be developmental where it seeks to enhance coping skills and social supports across a range of service types and compensatory where family support seeks to enhance and overcome disabling factors on families such as disadvantage and adversity, across service types such as day nurseries, specialised youth programmes and generally programmes that aim to offset the effects of social exclusion. Of most importance in this study's context is the "protective" category of family support which is concerned with building the strengths of the family through valuing the internal potential and positivity inherent in families rather than focus on negatives (McDonald et al., 2002). The family strengths perspective of family support is based on family risk and protective factors. The importance of this approach is that in the field of drugs for instance, "clustering of protective factors…can help a child and family withstand" stress which are maybe economic or social in origin or a combination of stresses. Gilligan (2000) concludes this understanding of family support by noting that: "the challenge for family support is to achieve a favourable balance between risk and protective factors…"

From looking at what family support entails, the question remains of what problems in families does family support target. As noted earlier, the family is seen collectively as a good and vital part of the structure of societies and as such, supporting the family in all its forms is a key part of this emphasis. Nevertheless, McKeown suggests individuals are harmed when the family is not functioning as a nurturing and protective setting[14]. These processes are contrasted with family circumstances that are more positive and which produce on the whole personal well-being on the part of those in families and relationships[15].

In terms of drugs and family support, Nic Gabhainn & Walsh (2000) highlight that drug prevention has broadened its horizons by acknowledging that "the support systems required by people are as diverse as their individual needs. It has finally matured away from a singular focus on the individual." This underlines the importance therefore of the role of the family and the community in the context of "multimodal strategies". In this sense, for drug prevention "a combination of strategies appears to work synergistically to promote more effectiveness than any single initiative" yet, the authors warn that "there is still need for much more work in this area if drug prevention is to successfully use the potential of family and community support (Nic Gabhainn & Walsh, 2000)." The implication of this is that the services that work under the general ambit of family support need to have a clearer, more defined and resourced role in drug prevention than is presently the case.

14 This type of harm is particularly harsh on children in such settings and the implication of such neglect or abuse has been shown to lead to problems in later life. McKeown (2000) also cites research which suggests that negative family circumstances, conflict and neglect can lead to physical and material hardship.

15 It should be noted that these effects are moderated by other factors such as high and low income, employment and unemployment. In the present context we can add to such problems as drug misuse, though drug problems can be both a cause and result of family and relationship problems.

Nevertheless, from our previous discussion of risk and protective factors for problem drug use, the impact of drug use on families and the role of the family in drug prevention, it is obvious that there is an interrelationship between family support and family-based drug prevention. Previous work completed for the NACD by Morgan puts this succinctly when he states: "It is clear from the review of [family] risk factors that have been identified as major risk factors in problem drug use are the same as those for school failure, anti-social behaviour and problems associated with poverty. For this reason, while interventions have targeted particular outcomes (substance misuse, school performance and social behaviour), and successful interventions are likely to have positive consequences for other features of development whether they are the primary target or not[16]."

In other words, the broad and diverse range of services – and their respective focus areas (education, community development etc.) – that fall under the family support umbrella, and their provision of support to families and family members through bolstering protective factors to counter balance risk factors in respect to a wide range of social problems, have at a minimum significant potential to act to prevent problem drug use. Family support, in responding to the needs of families especially in disadvantaged communities, has the potential, due to its diversity, to contribute to primary, secondary and tertiary prevention of drug use problems. The key challenge for drug prevention therefore is to explore and build on this potential.

Aims of the Research

With this context in mind, drug prevention policy in Ireland has moved in recent times, as illustrated in the National Drugs Strategy 2001-2008 (Government of Ireland, 2001), from an emphasis at the level of the individual to one which covers communal and societal factors also. Drug policy has also moved from specialist agencies, to involvement of a wide range of agencies, acknowledging the "cross cutting" nature of drug use. This is seen in the funding and development of drug prevention initiatives based in communities, such as the Local Drugs Task Forces. This has led also to a focus on the role of the family in respect of drug problems and their prevention. In this context, it is not clear however that the role of families in drug prevention is being realised by family support services in Ireland[17]. Perhaps the important role that generic family support services themselves can play in strengthening families to be able to cope with drug issues in the family and in the community is not clear to them.

In turn, the Prevention Sub-Committee of the NACD developed the aims of the research[18]. The purpose of this research is to assess family support services with a view to establishing the following:

1) the extent to which current services explicitly identify drug problems as a target of their activities;

2) the extent to which family support work (that is both work done by drug agencies and general family support work which does not explicitly identify drug issues as one of its targets) may be judged to play a positive role in the prevention of drug problems; and,

3) the potential for expanding the scope of family support so as to enhance its capacity with regard to drug prevention.

16 Morgan (2001). Brackets added by present Author.

17 Definitions of what is meant by drug prevention, as used in the research, are outlined in the glossary of terms.

18 This research builds on Morgan's review of drug prevention research for the NACD (2001) and McKeown's review of family support services (2000).

In addition to the global aims of the research, the secondary aims of the research were as follows:

- Identify, categorise and map all of the main family support services, whether delivered directly by statutory bodies or by the voluntary sector, currently being provided throughout the country;
- Through data gathering with families and service providers, form conclusions as to the extent to which drug problems (primarily problems relating to the use of illicit drugs but not excluding alcohol as part of a poly drug use profile) are central to the difficulties experienced by the target families;
- Through data gathering with both families and professionals, establish what if any specific drug prevention work is done with these families;
- Provide evidence or otherwise for the effectiveness of family support – whether generic or explicitly targeted at drug issues – in preventing drug problems;
- Make recommendations for more effective use of existing family support as a means of preventing drug problems;
- Analyse and present its findings in terms of the role adequacy, role legitimacy, and role support framework that has been heavily used in the alcohol field.

The present report is structured in such a way as to address these research questions. This report is a summary of the main findings of, and based on, a larger technical report of a family study that was commissioned by NACD and completed by Unique Perspectives.

Chapter 2
Research Methodology

The methodology chosen for the research included a literature review, the development of a database of family support services (FSS), self-completion questionnaire survey among a sample of FSS, semi-structured interviews with services, and semi-structured interviews with the clients of services.

At the outset, it is important to emphasise that this approach, in line with the aims of the research, is service-led, rather than client needs-led. Thus the core focus of the study was on the services perspective, and their needs so as to enhance their drug prevention role and not therefore on an assessment of the needs of their clients.

The research process began with a literature review. This review was undertaken to inform the research about family support, family support services and their role in drug prevention. The review concentrated, in particular, on risk and protective factors in respect of drug problems with an emphasis on the family, and also on the role of family support in strengthening a family's capacity to act as a protective factor against problems related to drugs.

The survey phase of the research was preceded by a data mapping exercise. The mapping process began in October 2002 and with the aim of building a database of FSS across the six categories of family support identified by McKeown[19]. This process began with a letter requesting contact details for FSS in order to establish, firstly, a sample to circulate questionnaires to and, secondly, a database that would contribute to a larger process of mapping family support services in Ireland. These request letters were forwarded to public and voluntary bodies at national, regional and local level. Approximately 500 such request letters were issued. In addition to these requests, a wide-ranging internet and public database search was performed in order to identify further services falling into the categories. The mapping process proved to be substantially larger and subsequently took longer than envisaged and continued until March 2003[20].

From January to March, 2,000 of these services were entered onto the database for circulation of questionnaires. The final deadline for sending out the questionnaire was March 2003. Of the 2,000 family support services identified, the following numbers (see Table 2.1) of each type of services were included in the survey dissemination:

Table 2.1 Number of each category of FSS included in survey sample

	No. Sent	% Sent	No. Resp.	% Resp.[21]
Home-based Parent and Family Support Programmes	302	15%	146	32%
Child Development and Educational Interventions	314	16%	186	40%
Community Development	333	17%	147	32%
Youth Work	397	20%	141	31%
Therapeutic Work	388	19%	127	28%
Parent Education Programmes	266	13%	157	34%
TOTAL	**2000**	**100%**		

19 These are set out in McKeown's work (2000) for the Department of Health and Children as part of the evaluation of the Springboard Family Support Initiative. The six categories identified, and discussed in more detail in Chapter three are: Therapeutic Work; Child Development and Education Interventions; Youth Work; Community Development; Parent Education Programmes; and, Home-based Parent and Family Support Programmes.

20 Although a maximum of 2000 services were included in the survey, it is estimated that up to 3000 services could be mapped given more time.

21 These columns show the number and percentage breakdown of the responses to questionnaire when asked to indicate the type of family support interventions that best describe their work. Given the difference in the numbers of circulation to each type of intervention and the numbers of responses for each intervention, this suggests that services can fit into a number of the family support interventions concurrently. This issue is dealt with in more detail in the next chapter.

Of the 2,000 questionnaires circulated, 461 were returned. From feedback in respect of missing or wrong addresses, staff turnover and some services no longer being in existence, we estimate that real size of the sample is in the region of 1,750. In this light, 461 represent a response rate of 26%. Given that this is the first time that a study examining the role of family support in drug prevention has taken place in Ireland, the number of responses provides therefore a useful platform with which to begin the exploration of these issues.

The study used a self-completion questionnaire. This was developed over the course of October to December 2002 and included a number of revisions and piloting of a version of the questionnaire in November 2002 among a small number of FSS[22].

The study included two further stages, both of which were qualitative and involved in-depth interviews and/or focus groups with services, and separately, their clients. The purpose of the interviews was to add a qualitative aspect to the research and these took place between May and August 2003[23]. In the case of services, they were chosen from those who returned questionnaires in three locations: Dublin west[24], Limerick City and the part of the Western and North Western Health Board areas centred on Sligo[25]. These areas were chosen in order to get a small but representative sample of services in urban and rural areas and whether they had a major, minor or not a focus on drugs in their work. Seventeen semi-structured person-to-person interviews were carried out in total[26]. Semi-structured interviews were also carried out with a small number of clients of services in the above three locations. The interviews were carried out with clients of services that indicated they had either a major or minor focus on drugs in their family support work[27]. In all, fourteen interviews and one focus group took place. Seven interviews took place in Dublin west, four interviews and one focus group in Limerick City and four interviews in the Northwest[28].

There are a number of limitations in the research that should be noted at the outset:

- Although the research amassed a sizeable database of services, no definitive database of FSSs in Ireland currently exists. As such, this study is, and could not be, representative of all family support services and as such should be seen as a case study rather than a representative sample;
- It could be surmised that the services that responded to the questionnaire may have more contact or knowledge of clients and families with drug problems, than those services that did not respond to the survey, due to the drugs focus of the survey but we cannot be sure;

22 The piloting of the draft questionnaire resulted in amendments to the questionnaire before its ultimate completion. The questionnaire collected relevant data among the services on the following: location and catchment area; funding; categories of family support; proportion of clients presenting to the service with drug problems; proportion of clients who came from families with drug problems; frequency drugs contributed to the presenting problems of clients; focus on drugs in services work; work with clients; role adequacy, legitimacy, and support; effectiveness in preventing drugs; and, enhancements to improve prevention capacity.

23 Research consent forms were discussed, agreed and signed by all the qualitative research participants.

24 Areas of Dublin west of M50 Motorway.

25 Sligo, Roscommon and Mayo.

26 This comprised of six interviews each with services that have a major and minor focus on drugs, and five interviews with a service that had no focus on drugs. Six interviews took place in Dublin and the Northwest and five in Limerick. The interviews were conducted using a semi-structured format. The themes guiding the interviews were: drugs problems and difficulties experienced by families/clients; drug prevention work undertaken with these families/clients; services offered which prevent drug problems in families/clients; role legitimacy; role adequacy; role support; effectiveness of service in drug prevention; and, enhancing the drug prevention capacity of services.

27 In each case, only clients of services that indicated that a significant – at least 10% - number of their clients presented with drug problems, personally or in the family.

28 Each of the clients had a direct or indirect drug-related problem. The interviews were guided by the following themes: rational in using the service; difficulties caused by drug-related problems; supports received from the service; and, enhancing the responsiveness of the service.

- The mapping exercise identified services as belonging to one type of the six services only, however, the difference between each of the services is not watertight;
- Finally, the categorisation of services as having a major, minor or no focus on drugs in their family support work is arbitrary. It is a perception on the part of services. No definition of major, minor or having no focus on drugs was offered as part of the research[29].

Overall, this study represents a valuable insight into the role of family support services and drug prevention and as such the study is important in its own right, but also because it is the first of its kind to explore this issue in detail.

29 Services also offered their perceptions in respect of their effectiveness, role in drug prevention etc. Although the perceptions of FSS are important, it is worth emphasising that to establish the true impact of FSS in respect of these issues would require more systematic research.

Chapter 3
Family Support Services in Ireland

In the present chapter, we give a brief overview of the six broad categories of services that provide family support and then we present some profile and service provision information, using the six family support categories, in respect of the FSS that were included in this study. These six broad areas are as defined by McKeown (2000). A decision was made to use these categories, as they had been described previously in Irish research. This is not to suggest that other categorisations may be used elsewhere, in the past or in future international research.

Typology of Family Support Interventions

To encompass broadly what FSS do in terms of the varied needs and environments of families (and the potential for family support to play a role in drug prevention across the broad array of factors that can lead to drug problems); six modes of family support interventions have been identified (McKeown, 2000).

The first of these is therapeutic interventions (TI). Family support is by nature synonymous with therapeutic interventions even though they are not naturally assumed to fall within the ambit of family support. However, McKeown points out that the purpose of family support is to help children, young people, couples, and families overcome problems that they experience in their lives. In family support, TI takes the form of counselling and/or supportive listening and by implication is a form of therapy. The evidence suggests that therapy is effective in over 70% of cases. However, its effectiveness is affected by factors such as client characteristics and social support, therapeutic client relationship, client hopefulness, and therapeutic technique[30]. In the present context, McKeown notes that issues like drug use and addiction and prolonged or multiple problems in families can impact on the effectiveness of therapy. In terms of family support, psychotherapy, marital therapy, family therapy, elements of social work, counselling etc, comprise this type of intervention.

The second family support intervention is parent education (PE) programmes. Parenting programmes aim to offer parents skills and knowledge in parenting, which assist them to promote their children's physical, emotional, and intellectual development (French, 2000). The content of parent education is normally based on one or more of the following dimensions: information sharing, skill building, improving self-awareness, and problem sharing (Rylands, 1995). These programmes take place outside of the home and on a group basis. The benefits of parent education have been shown to be effective; however, it is not, like all family support interventions, effective in isolation and in cases where more extreme problems such as poverty are also present. Parent education is therefore one of the range of family support interventions that can be provided across a corresponding range of problems that families present with.

The third category of family support, home-based parent and family support (HBFS) programmes, can be universal, such as the public health nurse system, or selective, where they specifically target at risk families. The latter set of services is the focus of family support type interventions. McKeown cites research, which suggests that home based family support provides for the following: brings hard-to-access services – through transport, childcare, etc. – to families in need; social support to families; a hands-on focus to the needs of families; and assistance in responding to family difficulties at the earliest opportunity. Family support in the home include assistance with practical home tasks such as housework, or making and keeping appointments, information giving, providing advice and support in addition to more focused therapy. In Ireland, the most obvious type of service falling under this intervention category is the Community Mothers Programme, run in the eastern health region. Other home based family support includes health board family support workers, public health nurses and dedicated family support projects such as Springboard, that may include elements of home visitation

30 See also McKeown et al. (2002), for a further discussion of these factors.

Child development and educational interventions (CDEI) includes a broad base of services due to the different ages of children that they work with. Such interventions include crèches, nurseries, playgroups, homework clubs, after school clubs, home/school/community liaison schemes, and related types of services. The aim of the CDEI is, for the most part, to assist the development and education of children who live in disadvantaged circumstances. Although the child is the outward focus of the interventions, parents, schools and community-based supports can also be involved. The interventions work with pre-school children, children at primary school age and children in their early teens. The interventions under this category, which are focused and of high quality, have also been shown to produce positive benefits for their recipients in the long-term also, although the short-term benefits are more noticeable and likely.

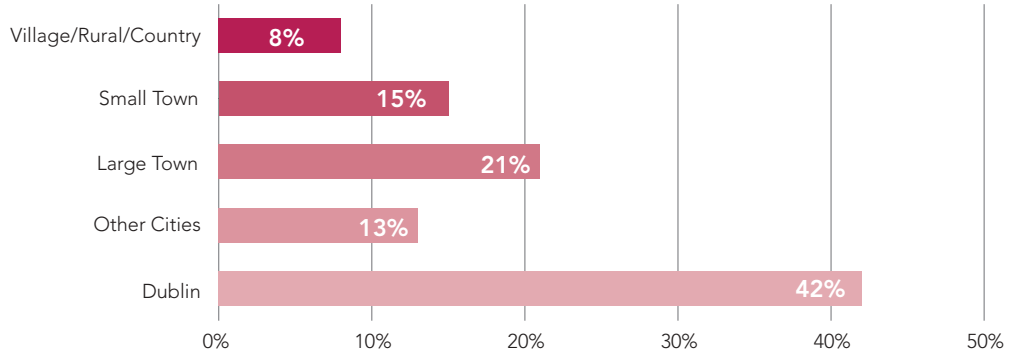
Youth work (YW) is also a type of family support intervention. Some of the key characteristics of youth work are as follows: it is a planned and systematic educational experience implemented outside of the formal school curriculum by voluntary youth organisations and groups; it is an active mode of learning which promotes an experiential learning model where young people are involved in learning by doing, in real life situations, and reflecting in a structured manner upon the experiences encountered; it provides structures whereby young people participate in decision-making, planning, organising, and evaluation; and it enables communities to meet the needs of their own young people (NYCI, 1994). From a family support perspective, the importance of youth work is its provision and focus on young people in disadvantaged areas. The significance of youth work and family support are where parents are involved and this is perhaps where the benefits of youth work to family support ultimately lie.

The final family support intervention identified by McKeown is community development (CD). Community development, in the broadest sense of the term, refers to the enhancement and progression of communities of one sort or another. However, the understanding of community development differs depending on the context in which it is applied or who is using it. One of the key debates in community development is that between product and/or process of CD. The Combat Poverty Agency (2002) understands CD as "people working together to clarify their needs, gain greater power and have more influence in the decision affecting their lives". In the context of family support, one recent comment highlights the importance of CD: "in tackling the exclusions and risks associated with contemporary society it makes to decreasing sense to view young people and families in isolation from the wider societies in which they live" (McGrath, 2003). This account observes therefore that one of the strengths of community development may be, apart from identifying the need for and the provision of services, its support to children and families in voicing their concerns and advocating on their behalf in respect of the processes and policies that negatively impact on their lives (McGrath, 2003).

Family Support Services in the Study

In our study, the geographic spread of family services indicates that the largest proportion, 42%, have their catchment area in Dublin. The country's other cities – namely Cork, Galway, Limerick and Waterford – accounted for 13% of services' catchment areas. 21% and 15% of services respectively are located in towns with a population more and less than 10,000. 8% of services operate in rural areas. This highlights that the vast majority of services in the survey are located in urban as opposed to rural areas and is likely to be an accurate reflection of the underlying reality.

Figure 3.1: Catchment type of services surveyed



The FSS responding to the survey represent all counties in the State. The county location of services mirrors the data provided above in the case of Dublin, in which 40% of services are located. 6% of services are located in Cork. The other counties that account for over 4% of services are Galway, Limerick and Tipperary.

The study examined the extent to which the catchment area of services in the sample could be described as disadvantaged by virtue of the location of an area-based initiative with a designated focus on disadvantage or drug problems[31]. The data reveals that 81% of services in the sample are located in disadvantaged areas. Fifty per cent of services surveyed are located in the catchment area of a Drugs Task Force, which suggests that these services have an increased prevalence of drug problems in their catchment areas in comparison to the remainder of the survey. It could also be said that this reinforces the importance of socio economic pressures on families, and the importance of providing support for them in these areas as they attempt to raise their children.

This study reveals that 60% of FSS surveyed suggest that more than one of the six categories of family support interventions, in the typology outlined above, described the work they do. Moreover, 27% and 15% of these services suggested they could be categorised according to two and three of the family support categories respectively. One tenth of the services indicated that their work fell under four categories of family support concurrently. This suggests that the six categories developed to describe family support interventions are not watertight. This finding seems also to highlight the diverse and complex work that a large proportion of services undertake and also that a significant share of services may operate a number of different programmes under the umbrella term 'family support'[32]. This may also demonstrate the diverse areas under which families require support concurrently and the response of a large proportion FSS to meeting these needs.

This trend is also borne out by the variety of funders that the services cite. 38% of services are funded by their respective Health Boards. The largest single funder of services in the study at 22%, is the Department of Social and Family Affairs. Eighteen per cent of FSSs receive their funding from the Department of Education and Science, and 17% from the Department of Health and Children. In organisational terms, 71% of services describe themselves as community, voluntary or other while the remaining 29% are a statutory service, which is in keeping with Murphy's observations about the substantial community and voluntary origins of FSS nationally.

31 The four initiatives are the Local Development Social Inclusion Programme implemented by Area Partnerships and Community Groups, Local Drugs Task Force Areas, RAPID and CLÁR.

32 Each of the six categories of FSS referred to 'other' as describing their work in the following proportions:
TI: PE 43%, CD 33%, CDEI 31%, HBPFS 30%, YW 26%.
CDEI: PE 62%, YW 51%, CD 50%, TI 44%, HBPFS 38%.
YW: CD 52%, CDEI 39%, PE 33%, TI 29%, HBPFS 17%.
CD: YW 54%, PE 43%, CDEI 39%, TI 38%, HBPFS 28%.
PE: TI 54%, CDEI 52%, CD 46%, HBPFS 40%, YW 37%.
HBPFS: PE 37%, TI 35%, CDEI 30%, CD 28%, YW 18%.

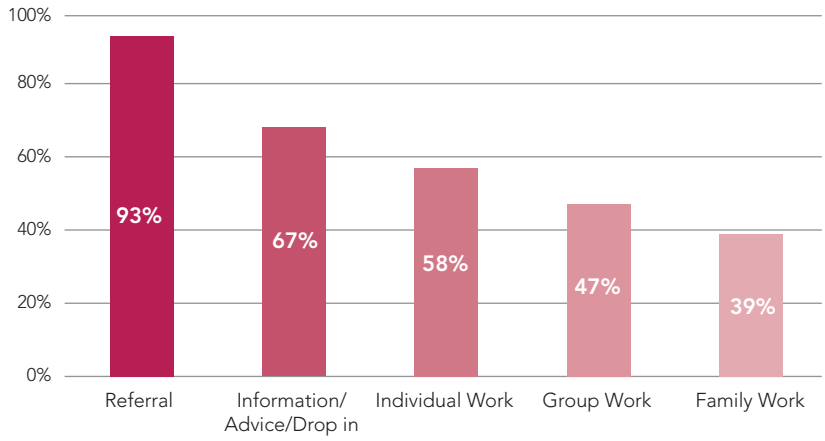
Table 3.1: Main sources of current funding

Main Source of Current Funding	All FSS
Health Board	38%
Dept. of Social & Family Affairs	22%
Dept. of Education & Science	18%
Dept. of Health and Children	17%
Other	14%
Dept. of Justice, Equality & Law Reform	13%
Vocational Education Committee	11%
Local Drugs Task Force	10%
Dept. of Community, Rural & Gaeltacht Affairs	8%
Area Partnership Company	5%
Other State Agency	5%
City of Dublin Youth Services Board	4%
City/County Council	4%
Foroige	2%
Garda Síochana	2%
National/Regional Youth Agency	2%
Dept. of Arts, Tourism & Sport	1%
National Voluntary Agency	0.5%

Services Provided to Drug Users and their Families

As well as the broad understanding of family support offered by the six family support interventions developed by McKeown (2000), family support is also characterised by the day-to-day interventions it offers to families and clients. The work of family support interventions can incorporate individual work, group work, family work, provision of information/advice and drop in service, and referral.

Figure 3.2: Services provided to clients with drug problems



This study found that among the responding services the most prevalent type of work undertaken with clients who presented with drug problems was, in nearly all cases (93%), referral. This high rate of referral is relatively constant regardless of whether services have a major, minor or no focus on drug issues or the extent to which services viewed drugs as a legitimate part of their work. It should be noted that referral is one of a range of responses that services can provide for drug problems among their clients. The high proportion of services citing referral perhaps underlines the complex nature of the drug problems that services come across and suggests that regardless of a services focus on drugs, services perceive that the needs of some clients presenting with drug problems goes beyond what services can provide. This is supported by some of the qualitative comments of the services which suggest that referral has three aspects: referral to specialist drug services, specialist services dealing with a non-drug related problem and formal structured referral. A further implication of this finding is that for FSS to provide services to clients with drug problems, preparation, skills, and support are required. In terms of the other types of work offered by services, 67% of FSS provided information, advice and drop in services to clients with drug problems. Fifty-eight per cent of surveyed services provided individual work; group work was undertaken by just less than half of services (47%) while 39% of services provided family work[33] to clients who presented with drug problems. This is an interesting finding and suggests that family work is the least likely activity undertaken by family support services.

The study suggests that the services offered to clients varied according to whether services have a major, minor or no focus on drugs. From the qualitative phase of the research, we established that services with a major focus provide for a wider range of family problems related to drugs than services with less of a focus on drugs. Services with a minor focus on drugs were generally less oriented toward drugs in their core activities by definition. They were, in general, more focused on their service type/approach or target groups. Services without any focus on drugs for the most part refer such clients to other services who are considered better placed.

From the client's perspective, the research suggests that the work of FSS fall into two main categories. The first of these is the provision of emotional support. Clients observe that what FSS do provides them with a 'sense of hope'. In this regard, clients noted that they felt services understood their circumstances and experiences and provided support, such as listening and counselling, which helped clients to address their problems in a positive way. The clients also cited the importance of the practical supports received from services, such as information and advocacy, as among the practical supports that best responded to their needs.

Overall, the wide focus areas of what FSS do, in responding to the problems that families present with, is noted by the broad range of services that can be encompassed across the six types of interventions they provide. However, in recognition of the multiple and varied influences on families and family functioning, such as poverty for example, no one intervention can be effective in isolation from a range of other concurrent interventions on the six-type range. This variegated view of what family support does is supported from the multiple ways FSS in the study describe their work across the six interventions types, as well as their funding and community/voluntary-statutory sector origins. These services differ in their response to drug problems depending largely on the extent to which they see drugs as a focus of their work.

33 Family work usually involves sessions with two or more members of the family for the purposes of assessing needs and meeting therapeutic goals (McKeown et al., 2001).

Chapter 4
Family Support Services and Identification of Drug Problems

In Ireland, the family has not to date been a prominent focus of national drug policy. Given that the family has become a key concern of social policy, this prominence is likely to increase in the coming years in a manner similar to the increased importance attributed to family support in general[34]. One implication of the limited focus attributed to the family in drug policy is that there has been little research in this country thus far on the role of family support in responding to drug problems. As such, it is not possible to come to any definitive conclusion as to the extent that family support services explicitly identify drug problems in their work[35].

Internationally, research has examined the role of the family in drug problems. This research focuses in particular on the risk and protective factors that the family can embody in respect to drug problems[36]. On the basis of the importance of the family as one of the factors and that can protect against or increase the risk of drug problems, a number of family-based drug prevention interventions have been put in place with the aim of strengthening family protective factors. Thus, these family interventions define, in many cases, successful models of family support that explicitly identify drug problems in their work[37]. Internationally, therefore, there are examples of family support interventions that explicitly target drugs in their activities.

It should be noted that family support services also vary as to whether they support the family as a means of drug prevention or support the family in their own right (Bancroft et al., 2003). Nevertheless, the explicit targeting of drug problems does not characterise all family support services by any means. As McKeown's description of family support interventions suggests, services which support families vary considerably under the umbrella term of family support, responding to drug problems is likely to be one of many explicit goals that characterises the work of family support.

Findings from the Study

As part of this study, we explored this issue by asking services to categorise themselves as to the extent that drug related problems are either a major, minor or not a focus of their family support work. The responses indicate that just over one fifth (21%) of services in our sample suggest that drug related problems are a major focus of their activities. Four out of ten FSS indicate that they have a minor focus on drugs and 39% of services surveyed stated they had no focus on drugs in their work.

The categorisation of services according to their perceived focus on drugs is also reflected in the proportion of clients who presented with drug problems that each of the three categories of services reported as working with; 70% of services with a major focus on drugs suggest that *over* 20% of their clients presented with drug problems. In contrast, 69% services with a minor focus on drugs report that *less* than 20% of their clients present with drug problems and this rises to 83% of services with no focus on drugs.

Overall, it may be the case, in the absence of representative survey data, that a minority of family support services formally and explicitly include drug problems as a target of their activities. The targeting of drugs may not be as wide as the responses received in this survey suggest. It is reasonable to assume that services who work with drugs were more likely to respond to a survey about drug

34 The study is arguably one point of a refocusing of drugs policy to include the family at national level.

35 However, there is anecdotal evidence that this is a growing focus of family support in some areas as represented by a conference addressing this issue in 2003. See Citywide, (2003).

36 This family risk and protective factors are discussed in more detail in the following chapters.

37 See Mitchell et al. (2001), Bancroft et al. (2003).

prevention. However, the implications of this, and as implied at least from the large proportion (79%) of services falling into the minor and no focus on drugs category, is that the bulk of family support services do not see themselves as having an explicit role in responding to drug problems, although some may come into contact with clients who present with drug problems. This is not surprising given that the family and thus FSS have not been a focus of drug prevention work to date in Ireland, nevertheless, this underlines the untapped potential of the bulk of family support services to play a more meaningful role in responding to drug related problems among their clients.

The qualitative phase of the research told us more about some of the differences between services that targeted drugs as part of their work and those services that do not. Services with a major focus on drugs cite drugs as the main contributory factor to the problems their clients presented with. In this sense, and in view that they provide for a wider range of supports for clients with drug problems, these services were comparatively better placed to provide support to the drug problems of their clients. Services with a minor focus on drugs in their work typically state that, while they come across clients with drug problems, responding to drug problems is not part of their main work. For these services drug problems are a direct and indirect contributory factor to the problems of individual clients and families. As such, although responding to drug problems is not central to the service, it is in their view becoming another prominent aspect that they must cope with in the families they seek to provide support to. Services who have no focus on drugs observe that drugs are becoming more prevalent among a small minority of their clients. Generally, these services do not screen or set out to assess if their clients have drug problems but report that problems related to drugs present over the course of providing supports to clients.

There were differences also in the types of drugs being used that each category of services saw in their clients. For services with major focus on drugs, alcohol was cited as the drug that most contributed to the problems they came across, however, this was matched and surpassed by illicit drugs in urban areas. While illicit drugs were also cited as being a problem for some clients in urban areas among services with a minor focus on drugs, the main drug that they came across in clients was alcohol. Where a drug related problem was identified in the client of services with no focus on drugs, it was typically related to alcohol. This suggests that alcohol is overall the main drug contributing to the problems of FSS clients.

The capacity of services to respond to drug problems among their clients was also coloured by their level of focus on drugs. The services with a major focus on drugs provided services to their clients along one or more of the six types of family support interventions with a clear emphasis on drug problems. Services in the minor focus category perceived that they function most effectively with their clients where there is limited or relatively recent drug-related problems. Services that do not focus on drugs suggest that where clients present with problems in which drugs are a problem, they do not provide support and look to refer such clients to what they consider to be more appropriate and skilled services. One implication of this is that the capacity of services to play a more meaningful role in responding to drug problems has the potential to be improved. One obvious way to increase the capacity of services is through additional information and the provision of training, with respect to drug problems and its relevance to their work, to FSS who do not at present perceive that they have the capacity undertake this work.

To sum up, the family has not been a leading focus of drug prevention activities (or funding) in Ireland and it follows from this that responding to drug problems has similarly not been to date a significant focus of services that provide support to families. This is probably also a legacy of the specialist approach to drugs which has been prevalent, not only in Ireland, but elsewhere. In this approach, generic agencies were encouraged to see drug issues as not in their realm of expertise. This is reflected also in the findings of this study in which a minority, one fifth, of FSS state that drugs are a major focus of their work. The majority of surveyed FSS suggest, in contrast, that drugs are a minor, or not at all a, focus of their actions in supporting families. These differential emphases on drugs in the work of FSS are reflected in the proportion of their clients presenting with drug problems. Internationally, the role of the family in acting to protect against drug problems has been explored and has resulted in the development of a number of drug-specific FSS or family-based prevention interventions with the aim of strengthening the family protective factor against drug problems. This study suggests that FSS with a major focus on drugs are those that provide services to families with drug problems and are best placed to do so. This nevertheless implies that there is considerable potential for the majority of FSS to contribute to drug prevention in their family support work by increasing their capacity to respond to drug problems and adding this to their normal canon of services. In addition, by increasing their understanding that the services they do provide are important for the prevention of drugs problems. A further implication of these findings is that this potential seems to be largely untapped at present.

Chapter 5
The Role of Problem Drug Use in the Delivery of Family Support Services

Findings from the Survey

In examining the extent to which drug problems may be considered as playing a role in the problems of the clients of FSS, information was collected from the surveyed FSS with regard to the range of family problems that their clients presented with. Services were asked to indicate the frequency with which drugs contributed to the presenting problems of clients. Overall, drugs contributed frequently or very frequently to the individual problems such as stress/depression (61%) and low self-esteem/ self-confidence (66%). For family relationships, drugs were seen as a contributory factor in problems between parents (61%), with parents (61%) and in parenting difficulties (59%).

The contribution of drugs to family difficulties is most acute for services with a major focus on drugs. For this group of services, drugs are a contributory factor frequently or very frequently to four particular presenting problems in 90% of their clients: behavioural/emotional problems (96%), low self-esteem/ self-confidence (92%), stress/depression (90%) and relationship problems between parents (90%). For major focus services, family problems such as problems with parents (87%) and parenting difficulties (84%), and individual problems such as isolation/lack of social support network (84%) and early school leaving (82%) were frequently or very frequently contributed to, by drugs, to a high degree.

For services with a minor focus on drugs, drugs contributed frequently or very frequently to individual problems such as low self-esteem/self-confidence (74%), behavioural/emotional problems (66%), parent/child in trouble with the law (64%), and stress/depression (63%). In family relationship problems, drugs were a contributory problem, frequently or very frequently, to parenting difficulties (67%), relationship problems between parents (65%) and relationship problems with parents (60%).

Findings from the Interviews

The qualitative phase of the research also explored the experiences of services with regard to drug problems in families. The services noted an overlap in the problems of individual clients and those of families. The drug related problems that services noticed in their individual clients centred on firstly, the negative impact that drugs had on individuals, which services felt lessened clients' ability to gain from the work of the service, and secondly, denial by individual clients of the relationship of their problems to drugs.

With this in mind, each of the services, regardless of the extent that they focus on drugs in their service, mentioned variants of the following as the drug related problems that emerged most in working with families: denial of drug misuse as a problem which negatively impacts the family; limited knowledge about the effects of drugs and apathy in families; reduction in family resources and coping skills; and the manner in which the whole family unit was affected by drug misuse by one of its members.

Research among the clients of services surveyed, highlighted the nature of how drug misuse was a problem in their family. The problems recounted related variously to either a spouse or partner's drug use including alcohol, parental drug use, or misuse by a child or sibling. In other words, substance misuse as reported by clients affected all members of the family. The type of drugs mentioned by clients also spanned the whole range of drug types: alcohol, illicit, and prescribed drugs. As a result of drug use in families, difficulties experienced for the family, and/or individuals, included relationship and marriage break-up, separation and divorce, children being put into care, domestic violence,

homelessness, physical and mental abuse, crime and other anti-social behaviour, exclusion from the extended family, depression and psychological problems, family financial difficulties, work and business problems, suicidal tendencies and also death.

The research among FSS clients as part of the study suggests that drug use contributed to a range of family difficulties. This is also mirrored in the experiences of a large number of services that took part in the survey. Many of the problems with which families present to services where drug misuse is a contributory factor, are also factors that increase the risk for subsequent drug misuse. Thus in families, drugs can be said to be both a cause and effect of family difficulties. This again underlines the potential role that family support services could play in drug prevention, through strengthening the protective factors in families.

Chapter 6

Do Family Support Services Play a Positive Role in the Prevention of Drug Problems?

Prevalence of Drug Problems

In order to answer this question, the study began by exploring the proportion of clients that presented to services with drug problems. This indicated that 38% of FSS in our sample have over 20% of their clients presenting with drug problems. As noted earlier, the proportion is highest for services with a major focus on drugs (70%). Just under one-third (31%) of services with a minor focus suggest that over 20% of their clients present with drug problems.

This pattern applies also to the prevalence of drugs in the family of clients. About one third (35%) of services stated that over 20% of their clients came from families with drug problems. The prevalence of drugs in the family of clients varies according to the focus of a service on drugs: 68% of services with a major focus suggest that over 20% of their clients come from families with drugs problems. About half (48%) of services with a minor focus see over 20% of their clients coming from families in which there are drug problems.

Nearly half of services stated that over 20% their clients come from families with problems related to Alcohol. The similar measure for illicit drugs was one fifth. This seems to emphasise the role of alcohol as the main drug that may contribute to problems in the clients and families that FSS see.

Table 6.1: Proportion of services with over 20% of clients coming from families with alcohol/illicit drugs problem

Drug Type	Proportion of Services	Proportion of Services by Focus on Drugs
Alcohol	47%	Major 78%, Minor 52%, No focus 27%
Illicit Drugs	20%	Major 61%, Minor 20%, No focus 8%

In light of the prevalence of drug use among the clients of FSS in our survey, research on family risk and protective factors for drug misuse, the role of family support services in strengthening protective factors in the family in general, it is plausible that FSS that are general and not specifically focused on drugs (that is aware of risk factors within the family for drugs for instance) may serve to strengthen family protective factors against drugs. However, there is no systematic evidence to support this in practice. What can be said however is that there exists significant potential for general FSS to play a positive role in drug prevention through strengthening families.

Drug Prevention Impact of Services

As part of the study, we explored the perceived impact of services in drugs prevention. In the responses, more than half (57%) agree that their services make a positive contribution to drug prevention although a considerably smaller number (38%) believe they are successful with clients who present with drugs problems. This may reflect the reality that success is difficult to achieve in working with drug issues, as other research has documented.

The study also explored what FSS believe is their contribution to the prevention of drugs across the four aspects, namely: primary, secondary, and tertiary prevention (types A and B).

Primary Prevention

Again, more than half of services disagreed that their work did not contribute to the prevention of drug problems prior to their onset.

Table 6.2: Proportion of services seeing themselves as having a primary prevention role

Focus of Services on Drugs	Proportion of Service
Major focus	49%
Minor focus	54%
Not a focus	57%

Secondary Prevention

In the case of secondary prevention, just under half of surveyed services believe they act to prevent drug problems where they are not yet fully manifest.

Table 6.3: Proportion of services seeing themselves as having a secondary prevention role

Focus of Services on Drugs	Proportion of Service
Major focus	48%
Minor focus	41%
Not a focus	46%

Tertiary Prevention (type A)

Half of all the services surveyed see the work that they undertake acting to prevent further harm to those whose symptoms of addiction are present (tertiary prevention type A).

Table 6.4: Proportion of services seeing themselves as having a tertiary prevention role (type A)

Focus of Services on Drugs	Proportion of Service
Major focus	69%
Minor focus	49%
Not a focus	40%

Tertiary Prevention (type B)

Thirty-eight per cent of FSS perceive that their service prevents drug problems recurring in those that have been treated.

Table 6.5: Proportion of services seeing themselves as having a tertiary prevention role (type B)

Focus of Services on Drugs	Proportion of Service
Major focus	55%
Minor focus	30%
Not a focus	28%

On the whole, these findings suggest that the services that took part in the survey believe that they make a positive contribution to drug prevention. However, where drug use has moved to a problematic stage, services with a more limited interaction, focus, or knowledge of drugs are less positive about their influence as a medium for drug prevention. It may be the case that services with more day-to-day knowledge of drugs and drug problems among their clients – services with a major focus – are responding on the basis of practical experience and services with a minor or no focus on drugs are responding to the questions about their role in principle rather than on the basis of practice.

The research through interviews also addressed the issue of the impact of services in addressing drugs. In similarity to the quantitative research, services interviewed in the major and minor focus on drugs groupings believed that they contributed positively to the addressing of drugs problems. Services without a focus on drugs were collectively unsure as to their level of impact in preventing drug use.

For all of the services interviewed, there was no systematic evidence or evaluation of the impact of FSS in preventing drug problems. Indeed, regardless of their focus on drugs, services interviewed do not test or measure their contribution to drug prevention among their clients. In one sense, since the majority of FSS do not formally focus on drug prevention as part of their work, there is no reason for them to measure their impact in this regard. This implies however that if existing FSS are to play a clearer role in drug prevention, they will need to implement an evaluation system to monitor their impact in preventing drugs. This of course will require resources and considerable work to design a system that best fits with the work of services and its relationship with problem drug use.

Overall, it is fair to assume that family support, through its work on strengthening the protective factors for drug misuse in families, has the potential to play a positive role in the prevention of drug problems. Most services to varying degrees believe that they contribute to drug prevention. However, research is required to establish the range of family support in drug prevention. What is evident, however, is that family support services come in contact with clients and families that have drug problems, we know also that family support can act to harness family protection factors which prevent drugs; this suggests that the drug prevention role of family support has potential given increases in the capacity of FSS to work with drug problems.

Chapter 7
Family Support Services and Perception of their Role in Drug Prevention

The study explored the role of FSS in drug prevention using what is referred to as the role insecurity framework. At the outset, role insecurity is a generic term that itself is comprised of three concepts, namely: role legitimacy, role adequacy and role support. The concept was first applied in the study of alcohol problems and specifically with its treatment by services in the community, as opposed to specialist services[38].

Role Insecurity Framework

The framework sets out to conceptualise the way in which, in this case family support, services deal with or respond to clients with drug problems. The origins of the framework relate to cases where clients with drug problems come into contact with specialist services only when such problems are pronounced. The framework is based on the assumption that clients with drug problems are more likely to seek support from and come into contact with a range of non-specialist services such as social workers, community-based groups etc., before presenting to specialist services. This assumption also implies that not all persons with drug problems will seek specialist attention, and as such, most individuals and families may seek support from non-specialist services. Non-specialist services may or may not possess the skills, knowledge, support structure or resources to adequately respond to drug related problems. Nevertheless, this assumption also highlights the potential of general, community-based non-specialist services to respond to drug problems.

The framework suggests that when non-specialist services come into contact with problems related to drugs, they may exhibit one or more of three anxieties. The first of these are anxieties about role legitimacy through being uncertain about the extent to which dealing with drinking problems fall within their professional and service responsibilities. Second, they may demonstrate anxieties also about role adequacy whereby they might not have the necessary skills and knowledge to recognise and respond to clients with drug problems and thirdly, they may reveal anxieties about role support through not having somewhere to turn for advice and help when they are unsure about what course of action to adopt in such cases.

In the present study, role insecurity provides us with a conceptual framework with which to interpret the manner in which family support services currently work with clients with drug problems and also what areas in particular may require further attention if the preventative role of family support services is to be enhanced in the future.

Findings from the Study

In order to explore these concepts, services were asked to indicate their level of agreement or disagreement to a number of statements based on each of the concepts.

Role Legitimacy

In the case of role legitimacy, just over six out of ten services (65%) see themselves as having a legitimate role in responding to the drug problems that their clients present with. About a quarter of services with a major focus on drugs believe they have no such role, which raises questions as to how they conceive of themselves as having a 'major focus' in their work on drugs. Three quarters of services

38 The role insecurity framework was first developed by Shaw et al. (1978). A definition of each of role legitimacy, role adequacy and role support are set out in the glossary of terms.

with a major focus on drugs see a legitimate role for themselves in addressing drug problems of clients. Conversely, more than half of services with no focus on drugs see themselves as having a legitimate role in meeting drug-related needs, which may suggest that in broad terms the FSS see themselves as having some role in drug prevention. The concept of role legitimacy was also explored with services in qualitative interviews. Among services with a major focus on drugs, it was generally recognised among these services that drug issues or drug use are a legitimate part of their work. Nevertheless, it is worth noting that some services construed their major focus on drugs as relating primarily to the type of problems that their clients present with rather than the service having an explicit and official drug remit. This may in part account for the one quarter of services in this category revealing problems in their role legitimacy. Services in the minor and no focus categories suggest that drugs are only a legitimate focus of their work where it contributes to the problems of their clients. It is worth reiterating here that the majority of services with a minor or no focus on drugs suggest that less than 20% of their clients present with drug problems. The interviews exploring role legitimacy seem to convey that the dividing lines between which services describe themselves as having a major, minor and no focus on drugs is arbitrary – but still real in the view of services – and the three categories overlap and may be better understood as a continuum. This conclusion is supported by the quantitative data also.

Role Adequacy

The data collected relating to role adequacy suggests that:

- Four out of ten FSS feel that they have the necessary skills and knowledge to respond to drug problems among their clients;
- 67% of services with a major focus on drugs do not see difficulties in the levels of role adequacy;
- However, only 36% of services with a minor focus and 26% of services with no focus on drugs believe that they have the necessary skills and knowledge in order to contribute to the prevention of drug problems among their clients.

This implies, as one would expect, that problems in role adequacy are more apparent for services in the survey that do not explicitly target drugs as part of their family support work. The interviews with services served to highlight the complexity of this issue. Firstly, services with a major focus on drugs, while feeling that they possessed necessary skills and knowledge to undertake this work, suggested that there was no limit on the skills that services required to undertake this work, and that the variety of drug problems may require more advanced or specialist skills. For services with a minor focus on drugs, it was recognised that the development of additional skills and knowledge was key to working with clients with drugs. Many in this grouping of services suggested that they did not know whether the skills and knowledge within the services were sufficient or not sufficient to work with clients who had drug problems. This seems to point to a basic lack of knowledge about drug issues and the needs of families presenting with drug-related problems for services that do not focus on drugs in their activities.

Role Support

The response of the services to statements about role support indicates that the majority (64%) believe that the level of support they currently can avail of is not sufficient to work successfully with clients with drugs problems. This view becomes more pronounced as the services' focus on drugs in their work

decreases; just over half (54%) of services with a major focus on drugs reveal problems with role support, two thirds (67%) of services with a minor focus and 71% of services with no focus on drugs respectively, exhibit difficulties with role support as part of their family support work where it concerns drugs. Among the services interviewed about role support, many of the services in the major focus category noted that while they could draw on support in general, this support was not always appropriate to drug issues and this served to hamper the coordination of services for families and individual clients with drug problems. It was also suggested that many of the specialist services focusing on drug issues on the ground are 'crisis-driven' and are not available to support drug prevention in FSS. For services that did not have an explicit focus on drugs, the responses clearly indicated that the necessary supports were not in place for their role in drug prevention.

Overall, the role insecurity framework was responded to differently by the services and the responses are difficult to interpret. Services are unclear as to whether they have a legitimate role in responding to drugs, even where they state that drugs are a major focus of their work. One explanation may be that although clients with drug problems present routinely to services with a major focus, and fewer to services with a minor focus, supporting such clients and drug issues may not be officially in the remit of such services. This may account for why some services suggest that, on the one hand, they have a major focus on drugs, and on the other, that responding to drug problems is not a legitimate focus of their work. The opposite may be true for services with a minor focus on drugs whereby they may not officially cater for drug issues, the numbers of their general clients, with problems relating to drugs, may make responding to such problems a legitimate part of their work by virtue of their client's needs. Finally, this may also suggest that the majority of services feel that drug issues should be a legitimate part of their official focus in the future. In terms of role adequacy, it is clear that training, skills, and knowledge in respect of responding to drug problems is required for all three categories of services. The greatest need for such skills, where FSS would respond to drug problems, is seen in the case of services with a minor and no focus on drugs at present. This implies that there are also likely to be significant differences in the level of training and skills development required by services across the three categories. The need of support for services in responding to drug problems is significant across all three levels. This suggests, in a manner similar to role adequacy, that the support needs of services at the minor and no focus levels is considerable. These findings go some way to highlight, in general terms, the nature of needs that services would require in order to enhance their role in drug prevention work with families.

Chapter 8
Helping Family Support Services Play a Greater Role in Responding to Drug Problems

In the self-completion questionnaire and in-depth interview phases of the study, we explored what the services and their clients perceived would enhance their drug prevention role. The response of services varied depending on the location, work undertaken, or a services' focus on drugs etc., however, they can be summarised around a number of themes. It is worth emphasising that these themes should not be viewed as mutually exclusive but rather as inter-related.

New Programmes/Initiatives

These might include focusing on new service areas or target groups. The target groups mentioned most often for additional programmes are parents, young people living in 'at risk' circumstances such as families where drug use is prevalent or a disadvantaged neighbourhood, younger children 'at risk' and lone parents – especially first time and teenage parents. It is noticeable in the responses that there was a particular emphasis on involving parents in the delivery of services. The involvement of parents was also cited by clients as one way to develop the prevention role of services, for instance, clients suggested that it would be beneficial to have increased parental involvement in drug awareness sessions with their children as a preventative measure, in that there should be more joint courses/ sessions/programmes for parents and their children in primary or early secondary schools. Many of FSS suggested that additions to existing service areas may also include: enhancing the family centred approach of services (a view also put forward by clients); and, specialist programmes alongside the existing services so as to enhance their role in drug prevention such as counselling, early intervention, parenting programmes and specialist family support and drug workers. Clients suggested that a greater presence by services 'on the ground' would also add to their role in drug prevention.

Resources

By resources, services refer to material supports of one form or another that, if developed, would enhance the ability of services to better facilitate a drug prevention aspect of their work. Included under this heading is the provision of additional information: information resources mentioned by respondents range widely from information about drugs in general and specific drugs, to information about preventative work and existing drug services in their respective localities. The importance of information to the prevention work of FSS was also made by clients. Other types of resources also identified by services to support new or additional preventative work included staff, premises/facilities, and funding.

Promotion

There were two aspects to the views of services under this theme. The term promotion can refer to raising awareness of the work of the services and thereafter, of problems associated with drug misuse. The promotion of the services means communicating the work, activities, and benefits to those in the catchment area of the service at risk of drugs use. There is a sense also in the responses that this aspect of promotion includes referral from other agencies, direct communication with families and the general communities in which services are based. This overlaps with the suggestion from clients of the need for FSS to increase awareness of services, both to their key target group clients, but also to other service providers and support groups who can act as referral agents and/or who the service will itself refer clients

to. The second element of this theme is about promoting awareness of the dangers associated with drug use, such as awareness campaigns that seek to deglamourise drugs and alcohol in particular. The responses intimate this type of campaigning would take place in the media and would be undertaken by the service but also by statutory bodies both locally and nationally, with the input of the services.

Co-ordination and Integration

This theme referred to the co-ordination and closer integration of family support services toward drug prevention ends. The developments noted include formal referral systems, closer integration of community based and voluntary groups and statutory services, thus facilitating greater drug prevention. In this regard, it was suggested by clients that existing services, centres and other support providers needed to increase communication with each other and increase the co-ordination and integration of service provision in order to better respond to the needs of clients with drug problems.

Training

Training figured also as one of the key themes that would enhance the drug preventative work of FSS. The background of the need for training, in this context, was that sufficient skills with which to undertake preventative work were not available to the majority of services. Training was seen as an important means with which to update the current range of skills of staff within services. This thinking varied from significant updating and training in order to include drug prevention work in services' activities to training and skills updating for a small number of staff who were in contact with families and individual clients who were deemed to be at risk of drug misuse. On the whole, there was a sense that training should be broad in nature with respect to drugs and preventative work and its relationship to family support. The need for training, skills and knowledge development was also recounted by clients, however, they suggested additional training for services should focus on drug problems in families as well as the communities in which they live.

Mainstreaming Drug Prevention Work

This set of views suggests that drug prevention work could be enhanced by its explicit inclusion across the range of work that any one service currently carries out. The responses refer to internal changes in the way services operate with a view to enhancing their drug prevention capacity. The responses in general are of two varieties. The first conveys the need to infuse existing services with a drug prevention focus and the second suggests practical sites of how and where this may be done. Beyond the general need to integrate drug prevention focus into the work of the respective services, the practical steps noted include:

- the development of systems, policies and protocols for drug prevention;
- integrating family systems approach;
- ensuring the appropriate materials are available to services to do this work;
- research the drug issue among clients and localities in order to facilitate the planned response of the service;
- changing work practices, early warning and early interventions, and longer opening hours.

One of the most important aspects of what the services and clients suggest would enhance their drug prevention role, is the manner by which it overlaps with the areas that the research on family-based drug interventions suggested were important for increasing the capacity of services to respond to drugs problems. These are:

- resources and appropriate funding models;
- training for staff;
- development of interagency links and protocols;
- knowledge of community attitudes; and,
- evaluation to see if the work undertaken contributes to drug prevention.

Chapter 9
Key Issues Emerging from this Study

Overall, this study suggests that FSS have the potential to play a greater role in drug prevention. However, in order to fulfil this potential, some amendments and changes are required in the focus, knowledge, and operations of FSS. This is the subject matter of this final chapter.

Based on the study and without reiterating its findings, there are number of broad issues that emerge which provide the platform for further consideration and action in order to enhance the role that existing (and future) family support services play in responding to and preventing drug problems, they are:

1. Although there has been a welcome expansion of family support services in Ireland, this study suggests that the majority of these are not aware, either through lack of knowledge/skills or the officially sanctioned boundaries of a service's focus, of the positive role they could play in responding to and preventing drug, including alcohol, problems. The prime example of this in the research is the very high proportion of services that, among other types of work provided, may refer clients who present with drug-related problems. This should be tackled by means of introducing the role of drug prevention into the professional training of those who work in family support; increasing the awareness and knowledge of existing family support services in respect of family functioning and preventing drugs; and the introduction of ongoing training for those that work in and manage family support services. In the medium term this process would considerably enhance the role of such services in responding to drug problems among their clients while also enhancing drug prevention more broadly in the communities in which they operate.

2. Following on from the issue above, the organisational and policy structure in which the broad range of Irish family support services are located also has a role in facilitating these services to develop a more explicit function in relation to responding to drugs and family problems. This could take place following the results of further pieces of research suggested here also. One obvious implication of FSS playing a greater role in drug prevention is the need for such a role to be adequately resourced, officially sanctioned, and mainstreamed in policy terms.

3. The literature highlights that family-based drug preventions have proved effective in strengthening the family as a protective factor against drug misuse. To date, no research has taken place in Ireland which explores the effectiveness of family support in drug prevention. This requires the initiation of research into the effectiveness of the family support approach to drug prevention. The learning from this process should be factored into further development of family support services.

4. FSS services do not at present systematically measure their respective impact in terms of drug prevention. If they are to play a greater role in responding to drug problems, it is important that the variety of services can have some means to measure the effectiveness of their work in this regard. Due to the diversity of FSS and their respective roles regarding families and drug problems, considerable thought and resources are required to assist services to develop evaluation and monitoring systems that are appropriate to the service and to allow also for services to enhance their role in drug prevention.

5. The research highlights repeatedly some of the problems that exist for services in terms of support and the lack of co-ordination and integration of services. This need for a multi-dimensional and integrated (interagency) approach is also made throughout the literature in respect of responding to the multi-faceted causes of drug problems. This issue is also addressed in the National Drugs

Strategy 2001-2008 (Government of Ireland, 2001). Both families and drugs problems are issues that cross organisational and sectoral boundaries. It follows that increased and planned co-ordination of services that deal with these issues is crucial. This, like all efforts at meaningful service co-ordination, will prove challenging in more closely linking the role and work of services across the six types of family interventions identified as well as statutory and community/voluntary FSS.

6. Many of the issues raised above and throughout the study involve the issue of communication at various levels. Communication needs to be addressed at a number of levels as follows: inter-FSS communication; communication between FSS and the local community and families; communication between regional/national central agencies/Government Departments and FSS providers; and communication between FSS and regional/national non-governmental agencies and bodies. This should be seen as one of the first steps in enhancing the role of family support services in contributing to drug prevention.

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NDP
NATIONAL DEVELOPMENT PLAN

Your Plan - Your Future

NACD
National Advisory
Committee on Drugs

3rd Floor
Shelbourne House
Shelbourne Road
Ballsbridge
Dublin 4

Tel: 01 667 0760

Web: www.nacd.ie
email: info@nacd.ie